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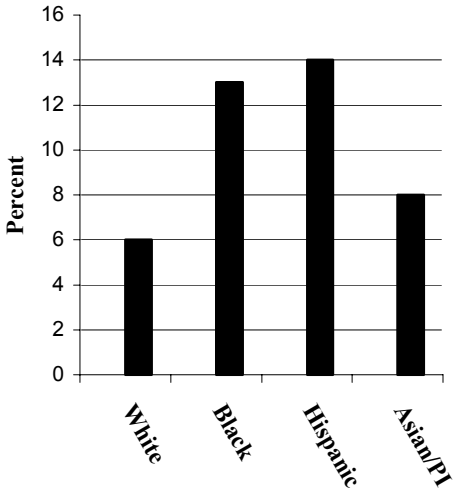
Disparities in Health Care

As advances in medical knowledge and technology have increased the effectiveness of health care services, disparities in access, delivery, and quality of health care have drawn increasing attention. This *ERIC Notebook* reviews societal and individual characteristics that contribute to disparities among people of different racial/ethnic groups, socioeconomic levels, and geographic residences.

The issue of health care disparities was addressed in the 1985 Report of the Secretary's Task Force on Black and Minority Health[1] and Healthy People 2000[2] and 2010[3]. In 2002, the Institute of Medicine issued *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, the first in a series of reports focusing on disparities in health care.[4] These landmark reports found that racial/ethnic minorities experience differences in health insurance coverage, access to treatment, health outcomes, and utilization of health care services due to socioeconomic status, discrimination, beliefs and attitudes of patients and physicians, and other factors.[1,2]

Adults reporting Emergency room or no regular source of health care, 2001



Source: Data from the Commonwealth Fund[5]

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SPECIAL ANNOUNCEMENT

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Disparities in health care have been documented for a wide range of health care services, settings, and financing arrangements. For example, among bone-fracture patients seen in the emergency department, Todd *et al.*[6] found that white patients were significantly more likely to receive analgesics than were African American patients with similar pain complaints. In a national analysis of health care use, Corbie-Smith *et al.*[8] found that Hispanics were less likely to receive blood pressure screening compared with whites and African Americans. Also, a report from the Surgeon General in 2001 found that African Americans, American Indians and Alaska Natives, Asian/Pacific Islanders, and Hispanics have less access to mental health care services compared with whites.[8]

Barriers to Quality Health Care

Major determinants of disparities in health care between racial/ethnic groups include: financial access to health care services,[9,11] socioeconomic status (SES),[1,2,9] geographic location,[9,10] racism and discrimination,[2] culture and language barriers,[12] preferences and beliefs on the part of the patients and providers,[11,13] and patient-provider interaction.[11,14,15] The remaining

sections of this issue review these factors that contribute to health care disparities.

Buying Health Care in America

Despite recurrent efforts to achieve health care for all, the United States remains the only industrialized country without universal health care coverage.[16] The result is increased vulnerability to health care disparities.

National health care reform initiatives have repeatedly attempted to change the US system of health care.[17,18] In 1912, Theodore Roosevelt's platform included a national health service plan. The Wagner-Murray-Dingell bill, drafted in 1943 by a group of Congressmen, labor unions, and members of the Committee for the Nation's Health, proposed a national medical insurance program.[17] The bill was defeated numerous times,[19] and support for it diminished with changes in the Congressional leadership. More recently, the Health Security bill proposed in 1993 and 1994 by the Clinton administration was defeated.[20]

In the absence of national health care coverage, obtaining health care generally depends upon having adequate resources[9] and/or access to employer or government programs.[18] Employer-provided insurance is the most common form of group insurance. For some portion or all of 2001, nearly 63 percent of Americans had a health insurance plan provided by an employer.[21] When available, coverage for dependents often requires the employee to pay the premiums.[22]

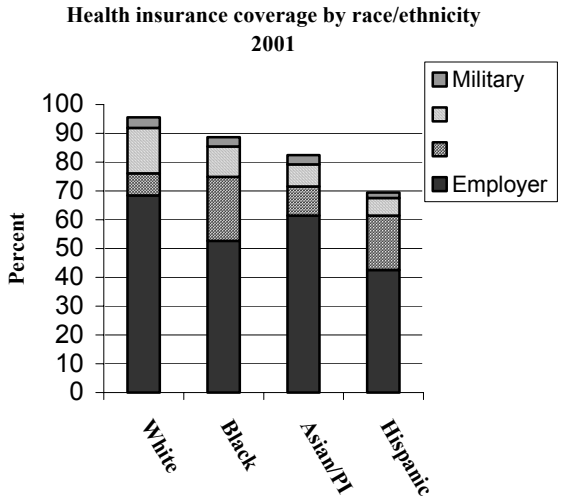
Employer-provided insurance is available primarily to permanent employees of large corporations or government. Insurance is only rarely provided to employees of smaller businesses or to persons working part-time. Insurance may sometimes be available through labor unions, professional groups, or other groups.[22] Individual health care insurance usually costs more and has more limited coverage than group plans. Individual plans also usually impose additional limits on coverage and charge higher premiums for persons with preexisting conditions.[22]

The U.S. government provides insurance to certain members of the population through Medicare,[23] Medicaid,[24] and the State Children's Health Insurance Program (SCHIP)[25] programs under the direction of the Centers for Medicare & Medicaid Services (CMS). The government also provides direct health services, though the Department of Defense,[26] Department of Veterans Affairs,[27] and Indian Health Service[28] (see table). Medicare primarily serves persons age 65 years and above.[23] Medicaid primarily serves the poor.[24] SCHIP serves low income children.[25] The Departments of Defense and Veterans Affairs provide health care services to active duty military personnel and veterans, respectively.[26,27]

The Indian Health Service (IHS) is a response to treaty obligations of the U.S. government.[29] Treaties between American Indian tribes and the United States state that the US government provide medical services for American Indians. The Snyder Act of 1921 and the Indian Health Improvement Act of 1976 require that funds be appropriated for health care of American Indians.[29]

The IHS was established in 1955 to provide "comprehensive health care services" to American Indians and Alaska Natives.[30] IHS provides primary and preventive health care services, including health care programs for nutrition, dental care, diabetes, and mental health. Currently, IHS provides health services to over 1 million American Indians and Alaska Natives.[30]

Like the services provided by the Veterans Health Administration, IHS is not an entitlement program. The level of services available depends upon the amount of funding appropriated each year.[31] Constituencies have raised concerns about IHS waiting lists for procedures. Many of IHS services are contracted out and become unavailable when funding is exhausted before the end of the fiscal year.[32]



Source: Data from US Census Bureau, 2002[21]

Not all insured persons have equivalent access to health care services, because the size of co-payments and deductibles and the scope of coverage vary widely across health insurance plans. Most plans reimburse costs only after a certain threshold amount (deductible) and then require the person to pay a percentage (copayment) of the covered expenses. Most plans do not cover certain categories of services, such as dental, optical, mental health care, and substance abuse.[4,33] Medicaid and Medicare restrict the provider's ability to charge patients more than the federally-allowed reimbursement. However in some areas it can be difficult to find a provider willing to accept Medicare or Medicaid patients because of the low reimbursements provided by these government programs.[34]

US Government Health Insurance Programs

Program	Funding	Eligibility	Coverage
Medicare	**Centers for Medicare & Medicaid Services (CMS)**	**Persons and spouses age 65 years or older with ≥ 10 years in Medicare covered employment, persons w/disabilities, and younger persons with a disability or end-stage renal disease[23]**	**Part A - covers inpatient care, hospice and some home health care Part B - (available for a monthly premium) covers outpatient care and some services not covered by Part A (physical & occupational therapy and home health care)[23]**
Medicaid	**CMS and states**	**Persons with very low income and resources (states determine eligibility standards that must at least meet federally defined minimums)[24]**	**Basic services (inpatient & outpatient care, medical and surgical dental services, rehabilitation, long-term care, home health, prenatal care, laboratory and x-ray services, etc), States determine services beyond basic services that must be available in all states.[35]**
State Children's Health Insurance Program (SCHIP)	**CMS and states**	**Uninsured children not eligible for Medicaid, under age 19, and ≤ 200% of the federal poverty level[25]**	**Same as Medicaid States determine services beyond basic services, and coverage is provided through separate state programs, expanded Medicaid programs, or a combination of both[36]**
Comprehensive Health Care Program	**Indian Health Service**	**Persons of Indian (American, Mexican, Canadian) and/or Alaskan descent (member of a recognized tribe, resident of tax-exempt or restricted property, involved in tribal affairs, regarded as such by the community), non-Indian woman pregnant w/eligible child, or non-Indian member of Indian household requiring treatment for disease control measures[28]**	**Primary, preventive, and rehabilitative services[31]**
TRICARE	**Department of Defense**	**Active duty, retirees, reservists, and medal of honor recipients, their spouses, and their unmarried children, including unremarried spouses and unmarried children of deceased service members[26]**	**Outpatient, inpatient, and nursing care,[37] under 3 levels: Standard, Prime, and Extra[38]**
Medical Benefits Package	**Department of Veterans Affairs**	**Available to enrolled veterans based on placement in priority groups[27]**	**Primary care, preventive, and specialty inpatient and outpatient services, including mental health and substance abuse treatment, home health care, hospice care, urgent care, prescription drugs, and long-term care.[39]**

America's Uninsured

Notwithstanding the panoply of insurance plans in the United States, in 2001, there were approximately 41 million persons in the United States who did not have any health insurance for some period of time, including 33 percent of Hispanics, 19 percent of African Americans, 18 percent of Asian/Pacific Islanders, and 10 percent of non-Hispanic Whites. Adults are particularly likely to be uninsured, especially adults aged 18-24, of whom an estimated 28 percent went without health insurance in 2001.[21]

SES and Disparities in Health Care

In addition to lack of health insurance, low income persons face additional constraints on access.[9] According to a 1997 report from the Center for Studying Health Systems Change, low income families were more likely to report decreased access to health care services within the previous three years.[40] Low-income persons are less likely to receive primary and preventive health care services that are important to overall individual health.[3,9] For example, in an analysis of the effect of socioeconomic factors on breast cancer stage at diagnosis, Lannin *et al*.[41] found that low income, having no form of private health insurance, and delaying a visit to a physician because of a lack of money were significantly associated with an advanced stage diagnosis. Also, in an analysis of indicators of quality diabetes care among low-income populations in North Carolina, Bell *et al*.[42] found that less than half of the patients received quality care.

Literacy and Health Care

One accompaniment of low SES is often limited literacy. Nationally, nearly 23 percent of adults in 1993 lacked reading and writing skills sufficient for the accomplishment of literacy tasks, such as the identification and interpretation of text within a document.[43] A patient's literacy level affects many aspects of the health care process, including access to health information, physician and patient communication about symptoms, diagnosis, and treatment, and utilization of preventive and screening services.[44] Persons with inadequate literacy skills are also more likely to be hospitalized and have higher health care costs compared with persons with adequate literacy skills.[45]

Racism and Discrimination

America's current system of health care has its roots in a racially segregated past.[46] Many racial/ethnic minorities, including American Indians, African Americans, and Hispanics, were excluded for many years and isolated from the mainstream health care system.[4] In spite of guarantees in various treaties and federal statutes, many American Indians have lacked access to basic health care services, especially prior to the establishment of the Indian Health Service.[47] When slaves received any care, it was usually through plantation hospitals.[34] Slaves were also subjected to medical experiments to demonstrate and confirm their supposed inferiority.[48]

Hospitals, medical schools, and nursing programs were highly segregated, and for many years, African Americans were denied treatment. Segregation of federally funded facilities was finally outlawed with the passage of the Civil Rights Act of 1964. Soon afterward, Medicare also required hospitals and nursing homes to discontinue discriminatory practices in order to be eligible for federal funding.[46] Nevertheless, the legacy of racism and discrimination remains apparent in today's health care system, and prejudice, bias, and cultural insensitivity on the part of health care providers contribute to disparities in health care.[4]

One of the most infamous examples of racism and discrimination in health care is the Tuskegee Syphilis Study. The study began in 1932 in Macon County, Alabama and was conducted by the US Public Health Service and many leading health officials. The original study group consisted of 412 African American men with syphilis and 204 African American male controls.[49] The study was initially projected to end after six to nine months,[34] but continued for another forty years, on the basis of flawed assumptions about the inferiority of African Americans and racial differences in the progression of syphilis.[41] During this period, penicillin became available as a treatment for syphilis. Study participants with syphilis were denied effective treatment in order to evaluate the natural history of syphilis in African Americans. The study ended abruptly in 1972 under the scrutiny of the media, politicians, health professionals, and the general population that viewed the study as highly unethical.[49]

Implications of Historical Racism in Health Care

The history of racism in services delivery and research has contributed to a general distrust and suspicion of the health care system on the part of many African Americans and other minorities.[48] This distrust encourages beliefs about genocidal conspiracies, leads patients to avoid the health care system, obstructs and distorts provider-patient communications, and reduces patient compliance.[4,11,13] Issues related to the Tuskegee Syphilis Study have been raised in relation to the current HIV/AIDS epidemic. Some persons believe that men in the study were injected with syphilis in an attempt to destroy the African American population.[48] Similar beliefs about AIDS have surfaced over the past decade. For example, a 1990 survey conducted by the Southern

Christian Leadership Conference found that 35 percent of the 1,056 church members surveyed believed AIDS was a form of genocide (described by Gamble [48]).

Language, Culture, and Health

Not all discrimination is intentional and not all disparities result from discrimination. Differences in language and culture contribute to disparities in health care.[12] Language differences create barriers to accessing quality care, and cultural differences between patients and providers contribute to disparities in health care, by influencing beliefs and behaviors; concepts of health; disease and disease management; and patient-provider interaction.[12]

Language

Effective communication is a fundamental element in the provision of health services.[5] A very basic impediment to effective communication exists where the patient and provider do not speak the same language. In 2000, about 18 percent of Americans spoke a language other than English at home, including over 28 million Americans who spoke Spanish, nearly 5 million Americans who spoke an Asian or Pacific Island language, and substantial numbers who spoke French, German, or Italian.[50] Language barriers reduce accessibility and timeliness of health care services, and interfere with interactions between the patient and physician.[12] Differences in language make it difficult or impossible for patients to describe symptoms effectively and for physicians to relay pertinent information for prevention, reassurance, and treatment.[12]

Culture

Cultural and linguistical competence refers to an "ability by health care providers and health care organizations to understand and respond effectively to the cultural and linguistic needs brought by patients to the health care encounter."[51] Culture has been defined as the "customary beliefs, social forms, and material traits of a racial, religious, or social group.[52,page 282]" Cultural concepts and beliefs about health and disease influence health care-seeking behaviors and responses to diagnosis and treatment. Great cultural diversity exists both across and within groups defined by conventional racial/ethnic classifications in the United States. For example, the category "Asian and Pacific Islanders" refers to people whose countries of origins contain nearly half of all people in the world. The people in this broad classification have very different languages, religions, dietary practices, social norms, and histories. Similarly, the category "American Indian" includes more than 500 recognized tribes in the United States.[53]

Patient-Physician Interaction

Interpersonal interaction affects patient's attitudes, adherence to physician instructions, and subsequent utilization of the health care system.[5,14] Interactions between patients and their providers have been found to be influenced by race/ethnicity, gender, and educational attainment.[54,55] For example, Kaplan *et al*.[54] found that minority and male patients, as well as patients without post secondary education, had the least interaction with their physicians. Furthermore, regional and class differences in the use of language, including pronunciation, vocabulary, and usage, can seriously impede communication. The social distance that is often present between patients from rural or less educated backgrounds and health care providers puts these patients at a disadvantage in communicating with providers and interferes with the provision of optimal care.[50,56]

Patient Preferences and Beliefs

Patient preferences also contribute to disparities in health care.[11,13] Practices and treatments of conventional medicine may not be congruent with traditional cultural beliefs and values of some ethnic groups.[12] Spiritual beliefs, as well as familial obligations and work, may prevent persons from accessing necessary prevention and treatment services.[57] Also, persons may turn to religious and cultural traditions for treatment instead of to procedures recommended by their physician.[13] Collins et al.[5] found that 27 percent of Asian American respondents, 22 percent of Hispanic respondents, and 12 percent of African American respondents, compared with 4 percent of white respondents, reported cultural or religious beliefs as a reason for choosing alternative care. To the extent that different treatment approaches yield different patient outcomes, differences in treatment preferences contribute to disparities in health.[13]

The Role of the Provider

Health care providers may hold conscious or unconscious beliefs about patients based on their behaviors and characteristics.[14] Van Ryn and Burke[15] found that patient race and SES were associated with a number of provider perceptions about patients regarding intelligence, personality, risk behaviors, and compliance with medical advice. Whites were about twice as likely as African Americans to be rated as at no risk for substance use and noncompliance. Patients in the lowest SES category were twice as likely to be rated as irresponsible and irrational compared with patients in the middle and upper SES categories.[15] Providers may feel that a patient is less deserving of treatment based on certain social or behavioral characteristics.[14] Also,

stereotyping by physicians may affect patient attitudes and perceptions and interactions between the patient and physician.[2,14]

Conclusion

Despite national efforts targeted at eliminating disparities in health care, substantial differences in the utilization, access, and quality of health care persist. Low-income, minority, and rural populations are disproportionately affected.[1,4,9] In this Notebook we have explored factors that contribute to disparities in health care. Although health disparities are a function of many factors, disparities in health care are an important and clearly recognized target for action.

Helpful Web Sites:

Agency for Healthcare Research and Quality
http://www.ahrq.gov

Center for Cross-Cultural Health
http://www.crosshealth.com/

Kaiser Family Foundation
http://www.kff.org/

National Association for Healthcare Quality
http://www.nahq.org

References:

1 US Department of Health and Human Services. (1985). *Report of the Secretary's Task Force on Black and Minority Health. Volume I.* Washington, DC: US Government Printing Office.

2 National Center for Health Statistics. (2001). *Healthy People 2000 final review*. Hyattsville, MD: Public Health Service.

3 US Department of Health and Human Services. (2000). *Healthy People 2010: access to quality health services*. Washington, DC: author.

4 Smedley, B.D., Stith, A.Y., & Nelson A.R. (eds.) (2002). *Unequal treatment: confronting racial and ethnic disparities in health care*. Washington, DC: National Academy Press.

5 Collins, K.S., Hughes, D.L., Doty, M.M., *et al*. (2002). *Diverse communities, common concerns: assessing health care quality for minority Americans*. New York: Commonwealth Fund.

6 Todd, K.H., Deaton, C., D'Adamo, A.P., Goe, L. (2000). Ethnicity and analgesic practice. *Annals of Emergency Medicine*, 35, 11-16.

7 Corbie-Smith, G., Flagg, E.W., Doyle, J.P., O'Brien, M.A. (2002). Influence of usual source of care on differences by race/ethnicity in receipt of preventive services. *Journal of General Internal Medicine*, 17, 458-464.

8 Office of the Surgeon General, US Department of Health and Human Services. (2001). Mental health: culture, race, and ethnicity (a supplement to Mental health: a report of the Surgeon General. Retrieved July 3, 2003 from http://www.surgeongeneral.gov/library/mentalhealth/cre/sma-01-3613.pdf

9 Fiscella, K., Franks, P., Gold, M.R., & Clancy, C.M. (2000). Inequality in quality, addressing socioeconomic, racial, and ethnic disparities in health care. *Journal of the American Medical Association*, 283, 2579-2584.

10 Shapiro, M.F., Morton, S.C., McCaffrey, D.F., Senterfitt, J.W., *et al*. (1999). Variations in the care of HIV-infected adults in the United States: results from the HIV cost and services utilization study. *Journal of the American Medical Association*, 281, 2305-2315.

11 Oddone, E.Z., Peterson, L.A., Weinberger, M., Freedman, J., Kressin, N.R. (2002). Contribution of the Veterans Health Administration in understanding racial disparities in access and utilization of health care, a spirit of inquiry. *Medical Care*, 40. S3-S13.

12 Diversity Rx. (1997) *Why language and culture are important*. New York, NY: author.

13 Katz, J.N. (2001). Patient preferences and health disparities. *Journal of the American Medical Association*, 286, 1506.1509.

14 Van Ryn, M. (2002). Research on the provider contribution to race/ethnicity disparities in medical care. *Medical Care*, 40, S140-S151.

15 Van Ryn, M., & Burke, J. (2000). The effect of patient race and socio-economic status on physicians' perceptions of patients. *Social Science & Medicine*, 50, 813-828.

16 Light, D.W. (2003). Universal health care: lessons from the British experience. *American Journal of Public Health*, 93, 25-30.

17 Hoffman, B. Health care reform and social movements in the United States. *American Journal of Public Health*, 93, 75-85

18 Birn, A., Brown, T.M., Fee, E., Lear, W.J. (2003). Struggles for national health reform in the United States. *American Journal of Public Health*, 93, 86-91.

19 Annis, E.R. (2002). Towards socialized medicine (part I): a historic chronology. *Medical Sentinel*, 7, 116-118.

20 Maher, W.B. (2003). Rekindling reform—how goes business? *American Journal of Public Health*, 92,92-95.

21 Mills, R.J. (2002). *Health insurance coverage: 2001*. Washington, DC: US Census Bureau.

22 Agency for Health Care Policy and Research. (1992). *Checkup on health insurance choices*. Rockville:Author.

23 US Department of Health and Human Services, Centers for Medicare and Medicare Services. (2003). *Medicare & You 2003*. (Publication No. CMS-10050). Washington, DC: US Government Printing Office.

24 Centers for Medicare and Medicaid Services. (2003). *Overview of the Medicaid program*. Retrieved May 17, 2003 from http://www.cms.gov/medicaid/mover.asp

25 American Academy of Pediatrics. (2003). *The State Children's Health Insurance Program*. Retreived May 18, 2003 from http://www.aap.org/advocacy/schipsum.htm

26 TRICARE. (2002). *TRICARE eligibility*. Retrieved April 24, 2003 from http://www.tricare.osd.mil/factsheets/index.cfm?fx=showfs&file_name=eligibility.htm

27 Department of Veterans Affairs. (2003). *Facts about the Department of Veterans Affairs*. Washington, DC: Author.

28 Indian Health Service. (2002). Eligibility requirements for health services from the Indian Health Service. Retrieved on May 27, 2003 from http://www.ihs.gov/GeneralWeb/HelpCenter/CustomerServices/elig.asp

29 Indian Health Service. (2001). *Basis for health services*. Retrieved on May 18, 2003 from http://info.ihs.gov/TreatiesLaws/Treaties_INDEX.asp

30 Indian Health Service. (2002). *Indian Health Service fact sheet.* Retrieved December 15, 2002 from http://www.ihs.gov/PublicInfo/PublicAffairs/Welcome_Info/ThisFacts.asp

31 Indian Health Services. (1999). Level of need funded cost model. Retrieved June 10, 2003 from http://www.his.gov/NonmedicalPrograms/LNF/Dld_files/p1sum.pdf

32 Kunitz, S.J. (1996). The history and politics of US health care policy for American Indians and Alaskan Natives. *American Journal of Public Health*, 86, 1464-1474.

33 Henry J. Kaiser Family Foundation. (2002). *Underinsured in America: is health coverage adequate*? Menlo Park, CA: Author.

34 Dula, A. & Goering, S. (eds.) (1994). "*It just ain't fair", the ethics of health care for African Americans*. Westport, Conn: Praeger.

35 Centers for Medicare and Medicaid Services. (2003). *Medicaid services*. Retrieved May 17, 2003 from http://www.cms.gov/medicaid/mservice.asp

36 Centers for Medicare and Medicaid Services. (2000). The State's Health Insurance Program: preliminary highlights of implementation and expansion. Retrieved April 13, 2003 from http://www.cms.gov/schip/wh0700.pdf

37 TRICARE. *TRICARE covered services and cost sharing.* Retrieved on May 17, 2003 from http://www.texvet.com/VeteranBenefits/brochures/PTF_TRICAREHandout.doc

38 TRICARE. (2003). *TRICARE handbook*. Retrieved on May 17, 2003 from http://www.tricare.osd.mil/TricareHandbook/

39 Department of Veterans Affairs. (2002). *VA health care and the medical benefits package*. Washington, DC: Author.

40 Lesser, C.S., Cunningham, P.J. Center for Studying Health Systems Change. (1997). *Access to care: is it improving or declining*? Washington, DC: Center for Studying Health Systems Change.

41 Lannin, D.R., Mathews, H.F., Mitchell, J., Swanson, M.S., *et al*. (1998). Influence of socioeconomic and cultural factors on racial differences in late-stage presentation of breast cancer. *Journal of the American Medical Association*, 279, 1801-1807.

42 Bell, R.A., Camacho, F., Goonan, K., Duren-Whitfield, V., et al. (2001). Quality of diabetes care among low-income patients in North Carolina. *American Journal of Preventive Medicine*, 21, 124-131.

43 Kirsch, I.S., Jungeblut, A., Jenkins, L., & Kelstad, A National Center for Education Statistics. (1993). *Adult literacy in America: a first look at the findings of the National Adult Literacy Survey*. Washington, DC: National Center for Education Statistics.

44 Ad hoc Committee on Health Literacy for the Council on Scientific Affairs, American Medical Association. (1999). *Journal of the American Medical Association*, 281, 552-557.

45 Baker, D.W., Parker, R.M., Williams, M.V., Clark, S. (1998). Health literacy and the risk of hospital admission. *Journal of General Internal Medicine*, 13, 791-798.

46 Smith, D.B. (1999). *Health care divided, race and healing a nation*. Ann Arbor: University of Michigan Press.

47 Bullough, V.L., & Bullough, B. (1982). *Health care for the other Americans*. New York: Appleton-Century-Crofts.

48 Gamble, V.N. (1997). Under the shadow of Tuskegee: African Americans and health care. *American Journal of Public Health*, 87, 1773-1778.

49 Jones, J.H. (1993). *Bad blood*. New York, NY: Free Press.

50 US Census Bureau. Summary tables on language use and English ability, 2000, PHC-T-20 (February 25, 2003): table 5.

51 U.S. Department of Health and Human Services, Office of Minority Health (2000). *Assuring cultural competence in health care: recommendations for national standards and an outcomes-focused research agenda*. Retrieved June 10, 2003 from http://www.omhrc.gov/clas/finalpo.htm

52 Mish, F.C., Morse, J.M., Copeland, R.D., Lowe, R.G., et al. (eds.) (1993). *Merriam-Webster's collegiate dictionary*. Springfield, MA: Merriam-Webster.

53 Pollard, K.M. & O'Hare, W.P. (1999) America's racial and ethnic minorities. *Population Bulletin*, 54. 1-44.

54 Kaplan, S.H., Gandek, B., Greenfield, S., Rogers, W., *et al*. (1995). Patient and visit characteristics related to physicians' participatory decision-making style. Results from the Medical Outcomes Study. *Medical Care*, 33, 1176-87.

55 Cooper-Patrick, L., Gallo, J.J., Gonzales, J.J., Vu H.T., et al. (1999). Race, gender, and partnership in the patient-physician relationship. *Journal of the American Medical Association*, 282, 583-589.

56 Robinson, M., Gilmartin, J. (2002). Barriers to communication between health practitioners and service users who are not fluent in English, *Nurse Education Today*, 22, 457-465.

57 Burhansstipanov, L. (2002). Leaders & survivors. In Bird, M.E., Bowekaty, M., Burhansstipanov, L., Cochran, P.L., Everingham, P.J., Suina, M. *Eliminating health disparities, conversations with American Indians and Alaska Natives* (pp 28-47). Santa Cruz: ETR Associates.

Additional Readings on the Topic:

Committee on the Consequences of Uninsurance, Board on Health Care Services, Institute of Medicine. (2001). *Coverage matters: insurance and health care*. Washington, DC: National Academy Press. http://www.nap.edu/books/0309076099/html/

Committee on the Consequences of Uninsurance, Board on Health Care Services, Institute of Medicine. (2002). *Care without coverage: too little, too late*. Washington, DC: National Academy Press. http://www.nap.edu/books/0309083435/html/].

Jha, A. K., Shlipak, M. G., Hosmer, W., Frances, C. D., & Browner, W. S. (2001). Racial differences in mortality among men hospitalized in the Veterans Affairs Health Care System. *JAMA, 285*, 297-303.

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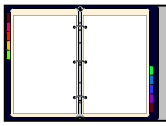
http://hsrd.durham.med.va.gov/ERIC/Education/Education.html



ERIC Notebook

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